NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

March 11, 2020

Administrator
The Hurlbut, LLC
1177 East Henrietta Road
Rochester, New York 14623

Re: MDS Final Audit Report
Audit #: 18-7902
Provider ID#: 00308558

Dear Administrator:

This is the final audit report of findings with regard to the Office of the Medicaid Inspector General's (OMIG) Minimum Data Set (MDS) audit of The Hurlbut, LLC for the census period ending July 25, 2016. In accordance with 18 NYCRR §517.6, this final audit report represents the OMIG's final determination on issues found during OMIG's review.

In your response to the draft audit report dated November 27, 2019, you identified specific audit findings with which you disagreed. Your comments have been considered (see Attachment D) and the report has been either revised accordingly and/or amended to address your comments (see Attachment D). Consideration of your comments resulted in an overall reduction of $0.00 to the total Medicaid overpayment shown in the draft audit report.

The Medicaid overpayment of $17,573.44 was calculated using the number of Medicaid days paid for the rate period January 1, 2017 through June 30, 2017 and the change in the direct component of your Medicaid rate as calculated by the Department of Health's Bureau of Long Term Care Reimbursement (BLTCR). The calculation of this overpayment is detailed in Attachment A. BLTCR will adjust your Medicaid rates for the relevant rate period to reflect the change in the direct component. The findings explanation, regulatory references, and applicable adjustment can be found in the attachments following Attachment A.

The Provider has the right to challenge this action and determination by requesting an administrative hearing within 60 days of the date of this notice. If the Provider wishes to request a hearing, the request must be submitted in writing to:

General Counsel
Office of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, NY 12204

Questions regarding the request for a hearing should be directed to Office of Counsel, at (518) 408-5845.

In accordance with 18 NYCRR 519.18(a), "The issues and documentation considered at the hearing are limited to issues directly relating to the final determination. An appellant may not raise issues regarding the methodology used to determine any rate of payment or fee, nor raise any new matter not considered by the department upon submission of objections to a draft audit or notice of proposed agency action."

If a hearing is held, you may have a person represent you or you may represent yourself. If you choose to be represented by someone other than an attorney, you must supply along with your hearing request a signed authorization permitting that person to represent you at the hearing; you may call witnesses and present documentary evidence on your behalf.

For a full listing of hearing rights please see 18 NYCRR Part 519.

Should you have any questions regarding the above, please contact Mary Guadrón, PhD, RN, RAC-CT at (518) 402-1623 or through email at Mary.Guadron@omig.ny.gov .

Sincerely,

Sharon Whitmore

Sharon Whitmore, Audit Manager
Division of Medicaid Audit
Office of the Medicaid Inspector General

SW/mr

Attachments:
ATTACHMENT A - Calculation of Medicaid Adjustment
ATTACHMENT B - Detailed Findings by Sample Number
ATTACHMENT C - Detailed Findings by Disallowance
ATTACHMENT D - Analysis of Provider Response

CERTIFIED MAIL # 7019 0700 0000 1671 5288
RETURN RECEIPT REQUESTED

ATTACHMENT A

OFFICE OF THE MEDICAID INSPECTOR GENERAL
THE HURLBUT
AUDIT # 18-7902
CALCULATION OF AUDIT IMPACT

RATE TYPE	DECREASED IN DIRECT COMPONENT OF RATE*	MEDICAID DAYS	IMPACT
Part B Eligible/Part B D Eligible	$1.04	16,339	$16,992.56
Non-Medicare/Part D Eligible	$1.06	548	$580.88
Total			$17,573.44

*Rounded to nearest 1/100th New York State Department of Health Bureau of Managed Long Term Care Rate Setting / FFS

OFFICE OF THE MEDICAID INSPECTOR GENERAL
THE HURLBUT
AUDIT #18-7902
ERRORS BY SAMPLE NUMBER

Sample #	DOB	Name	ARD	Reported RUG	Derived RUG	Reported RUG Weight	Derived RUG Weight	DETAILED FINDINGS: Disallow bed mobility self performance	Disallow bed mobility support provided	Disallow transfer self performance	Disallow transfer support provided	Disallow eating self performance	Disallow toilet use self performance	Disallow toilet use support provided	Disallow occupational therapy	Disallow physical therapy
1	6/4/1926	A.A.	5/24/2016	RMB	RMB	1.22	1.22									
2	2/26/1938	D.B.	6/14/2016	RHC	CB1	1.4	0.86							1	1	
3	4/14/1929	M.C.	6/21/2016	IB1	IB1	0.78	0.78									
4	5/21/1947	M.C.	5/14/2016	RMC	RMC	1.27	1.27									
5	7/5/1949	P.D.	6/14/2016	RMB	RMB	1.22	1.22									
6	7/28/1948	H.D.	7/12/2016	RMC	CB1	1.27	0.86							1	1	
7	8/12/1919	S.D.	7/5/2016	PE1	PE1	0.79	0.79				1					
8	4/1/1915	O.F.	6/14/2016	PB1	PB1	0.58	0.58									
9	10/5/1943	D.H.	7/9/2016	PD1	PD1	0.72	0.72									
10	1/15/1940	M.H.	5/21/2016	RMC	RMB	1.27	1.22		1	1			1			
11	3/21/1924	M.H.	4/29/2016	RMB	RMB	1.22	1.22									
12	1/27/1939	C.K.	7/10/2016	PE1	PE1	0.79	0.79						1			
13	1/31/1940	P.K.	7/19/2016	RHB	RHB	1.27	1.27									
14	8/23/1948	A.L.	5/3/2016	RHC	RHC	1.4	1.4									
15	4/15/1934	J.M.	7/5/2016	IB1	IB1	0.78	0.78									
16	6/1/1952	K.P.	7/29/2016	RVC	RVC	1.53	1.53									
17	10/7/1932	D.S.	5/31/2016	RMC	CB1	1.27	0.86	1		1			1		1	
18	4/6/1934	B.S.	6/6/2016	RVC	RVC	1.53	1.53									
19	9/30/1925	E.T.	5/31/2016	PE1	PE1	0.79	0.79	1		1			1			

OFFICE OF THE MEDICAID INSPECTOR GENERAL
THE HURLBUT
AUDIT #18-7902
ERRORS BY SAMPLE NUMBER

Sample #	DOB	Name	ARD	Reported RUG	Derived RUG	Reported RUG Weight	Derived RUG Weight	DETAILED FINDINGS: Disallow bed mobility self performance	Disallow bed mobility support provided	Disallow transfer self performance	Disallow transfer support provided	Disallow eating self performance	Disallow toilet use self performance	Disallow toilet use support provided	Disallow occupational therapy	Disallow physical therapy
20	4/12/1938	P.V.	7/19/2016	RHB	RHB	1.27	1.27									
21	4/24/1921	P.V.	5/1/2016	RMC	RMC	1.27	1.27						1			
22	3/14/1920	A.Y.	4/29/2016	RHC	RMA	1.4	1.17	1	1	1	1	1	1	1		
Totals								3	2	4	1	2	6	1	3	2

OFFICE OF THE MEDICAID INSPECTOR GENERAL
THE HURLBUT
AUDIT #18-7902
MDS DETAILED FINDINGS

Rules of General Applicability to the Findings Below:

To be considered as allowable in determining reimbursement rates, costs shall be properly chargeable to necessary patient care.

10 NYCRR 86-2.17(a)

...residential health care facilities shall submit to the department the data contained in the comprehensive assessment and review of assessments...required to be completed by facilities in accordance with section 415.11 of this Title and section 483.20 of 42 CFR (Minimum Data Set Plus for Nursing Home Resident Assessment and Care Screening [MDS+])...

10 NYCRR 86-2.37(a)

The direct component of the price shall be subject to a case mix adjustment in accordance with the following: The application of the relative Resource Utilization Groups System (RUGS-III) as published by the Centers for Medicare and Medicaid Services...

10 NYCRR 86-2.40(m)(1)

The adjustments and related patient classifications for each facility shall be subject to audit review by the Office of the Medicaid Inspector General.

10 NYCRR 86-2.40(m)(5)

The operator...shall submit to the Department a written certification...attesting that all of the "minimum data set" (MDS) data reported by the facility for each census roster submitted to the department is complete and accurate.

10 NYCRR 86-2.40(m)(9)

The facility shall conduct a comprehensive assessment of each resident's needs, which describes the resident's ability to perform daily life functions and identifies significant impairments in functional capacity. All comprehensive assessments completed on or after April 1, 1991 shall be recorded on a uniform data instrument designated by the Department of Health.

10 NYCRR 415.11(a)(1)

By enrolling the provider agrees:(a) to prepare and maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished...

18 NYCRR 504.3(a)

By enrolling the provider agrees:(e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons.

18 NYCRR 504.3(e)

All fiscal and statistical records and reports of providers which are used for the purpose of establishing rates of payment made in accordance with the medical assistance program and all underlying books, records, documentation and reports which formed the basis for such fiscal and statistical records and reports are subject to audit. All underlying books, records and documentation which formed the basis for the fiscal and statistical reports filed by a provider with any State agency responsible for the establishment of rates of payment or fees must be kept and maintained by the provider for a period of not less than six years from the date of filing of such reports, or the date upon which the fiscal and statistical records were required to be filed, or two years from the end of the last calendar year during any part of which a provider's rate or fee was based on the fiscal or statistical reports, whichever is later. In this respect, any rate of payment certified or established by the commissioner of the Department of Health or other official or agency responsible for establishing such rates will be construed to represent a provisional rate until an audit is performed and completed, or the period within which to conduct an audit has expired without such audit having been begun or notice of such audit having been issued, at which time such rate or adjusted rate will be construed to represent the final rate as to those items audited.

18 NYCRR 517.3(a)(1)

The department may require repayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted, or the person receiving payment for the claim.

18 NYCRR 518.3(a)

The department may require repayment for inappropriate, improper, unnecessary or excessive care, services or supplies from the person furnishing them, or the person under whose supervision they were furnished, or the person causing them to be furnished. In this respect, the department may recover the amount paid for such care, services or supplies from the person ordering or prescribing them even though payment was made to another person. Medical care, services or supplies ordered or prescribed will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client's medical record.

18 NYCRR 518.3(b)

(b)Comprehensive assessments -
(1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information.
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychosocial well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnoses and health conditions.
(xi) Dental and nutritional status.
(xii) Skin condition.
(xiii) Activity pursuit.

(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

42 CFR 483.20 (b)(1)

MDS FINDINGS	**SAMPLE SELECTION**
Functional Status-ADL Self-Performance and Support	
If the provider is unable to produce the supporting documentation for the resident, the service will be disallowed and the Case Mix will be adjusted. A repayment schedule will be developed.	
Documentation must support the MDS item responses regarding "the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion" (MDS 3.0 Manual, page G-1). MDS 3.0 manual guidelines will be followed when examining the medical records.	
MDS Manual 3.0 G0110-0900	
Bed Mobility Self-Performance	
In 2 instances, documentation did not support resident required total assist every time.	17, 19
In 1 instance, documentation did not support resident required weight-bearing assist three or more times.	22
Bed Mobility Support Provided	
In 1 instance, documentation did not support resident was a 2+ person physical help at least once.	10
In 1 instance, documentation did not support resident was a one-person physical help at least once.	22
Transfer Self-Performance	
In 3 instances, documentation did not support resident required total assist every time.	10, 17, 19

In 1 instance, documentation did not support resident required weight-bearing assist three or more times.	22

Transfer Support Provided

In 1 instance, documentation did not support resident was a one (1) person physical help at least once.	22

Eating Self-Performance

In 1 instance, documentation did not support resident required total assist every time.	7
In 1 instance, documentation did not support resident required supervision one or more times.	22

Toilet Use Self-Performance

In 4 instances, documentation did not support resident required total assist every time.	12, 17, 19, 21
In 2 instances, documentation did not support resident required weight-bearing assist three or more times.	10, 22

Toilet Use Support Provided

In 1 instance, documentation did not support resident was a one-person physical help at least once.	22

Skilled Therapy

If the provider is unable to produce the supporting documentation for the resident, the service will be disallowed and the Case Mix will be adjusted. A repayment schedule will be developed.

"Only skilled therapy time (i.e., requires the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS" (MDS 3.0 Manual, page O-19).

Documentation must support the MDS item responses regarding medically necessary therapies. "The qualified therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy provided to the residents. Rehabilitation (i.e., via Speech-Language Pathology Services and Occupational and Physical

Therapies) and respiratory, psychological, and recreational therapy can help residents to attain or maintain their highest level of well-being and improve their quality of life" (MDS 3.0 Manual, page O-16).

"The services must be reasonable and necessary for the treatment of the resident's condition. This includes the requirement that the amount, frequency, and duration of the services must be reasonable and they must be furnished by qualified personnel." (MDS 3.0 Manual, page O-20).

"The services must be directly and specifically related to an active written treatment plan that is approved by the physician after any needed consultation with the qualified therapist and is based on an initial evaluation performed by the qualified therapist prior to the start if services in the facility." (MDS 3.0 Manual, page O-20).

MDS 3.0 manual guidelines will be followed when reviewing the documentation provided by the facility.

MDS 3.0 Manual O0400-O0450

Occupational Therapy

In 1 instance, documentation did not support an order for therapy.	2
In 3 instances, the medical basis and specific need for the skilled therapy was not fully and properly documented within the medical record.	2, 6, 17

Physical Therapy

In 2 instances, the medical basis and specific need for the skilled therapy was not fully and properly documented within the medical record.	2, 6

RUGS-II Classifications Overturned

As a result of the above disallowances, in 6 instances, the RUG classifications were overturned.	2, 6, 10, 17, 22

OFFICE OF THE MEDICAID INSPECTOR GENERAL
THE HURLBUT
AUDIT #18-7902
ANALYSIS OF PROVIDER RESPONSE

Sample #	Finding	Provider Response	Accepted/Denied	Explanation
Sample # 2 D.B.	00400C Physical Therapy	• Cover letter with detailed explanation • F 675 Quality of Life • CMS Centers for Medicare and Medicaid Services (September 5, 2012) • The Hurlbut Policy and Procedure (Qualifiers for Restorative/ Maintenance OT/PT) • Physician's Orders • Physician's Progress Notes • Therapy evaluation and progress notes • Therapy days and minutes of treatments • Nutritional Assessment	Denied	The MDS with ARD 06/14/2016 claimed Skilled Physical Therapy 6 days/ 220 minutes. Facility documentation provided does not support the medical need for Skilled Physical Therapy services. The resident record does not document a medical basis or specific need to justify Physical Therapy evaluation and treatment. Resident Progress Notes contain no mention of any issues relevant to a need for Physical Therapy. Disallowance will be included in the Final Report. See MDS Manual Section O.
	00400B Occupational Therapy		Denied	The MDS with ARD 06/14/2016 claimed Skilled Occupational Therapy 5 days/ 135 minutes. Facility documentation does not support an order for Occupational Therapy. Facility documentation provided does not support the medical need for Skilled Occupational Therapy services. The resident record does not document a medical basis or specific need to justify Occupational Therapy evaluation and treatment. Resident Progress Notes contain no mention of any issues relevant to a need for Occupational Therapy. Disallowance will be included in the Final Report. See MDS Manual Section O.

				See MDS Manual Section O.
Sample # 6 H.D.	00400C Physical Therapy 00400B Occupational Therapy	• Cover letter with detailed explanation • F 675 Quality of Life • CMS Centers for Medicare and Medicaid Services (September 5, 2012) • The Hurlbut Policy and Procedure (Qualifiers for Restorative/ Maintenance OT/PT) • Physician's Orders • Physician's Progress Notes • Therapy evaluation and progress notes • Therapy days and minutes of treatments • Nutritional Assessment	Denied Denied	The MDS with ARD 07/12/2016 claimed Skilled Physical Therapy 4 days/ 105 minutes. Facility documentation provided does not support the medical need for Skilled Physical Therapy services. The resident record does not document a medical basis or specific need to justify Physical Therapy evaluation and treatment. Resident Progress Notes contain no mention of any issues relevant to a need for Physical Therapy. Disallowance will be included in the Final Report. See MDS Manual Section O. The MDS with ARD 07/12/2016 claimed Skilled Occupational Therapy 5 days/ 180 minutes. Facility documentation provided does not support the medical need for Skilled Occupational Therapy services. The resident record does not document a medical basis or specific need to justify Occupational Therapy evaluation and treatment. Resident Progress Notes contain no mention of any issues relevant to a need for Occupational Therapy. Disallowance will be included in the Final Report. See MDS Manual Section O.
Sample # 8 O.F.	K0200A BMI/ Height		Accepted	Disallowance reversed and will not be included in the final report.

Sample #17 D.S.	00400B Occupational Therapy	• Cover letter with detailed explanation • F 675 Quality of Life • CMS Centers for Medicare and Medicaid Services (September 5, 2012) • The Hurlbut Policy and Procedure (Qualifiers for Restorative/ Maintenance OT/PT) • Physician's Orders • Physician's Progress Notes • Therapy evaluation and progress notes • Therapy days and minutes of treatments • Nutritional Assessment	Denied	The MDS with ARD 05/31/2016 claimed Skilled Occupational Therapy 6 days/ 195 minutes. Facility documentation provided does not support the medical need for Skilled Occupational Therapy services. The resident record does not document a medical basis or specific need to justify Occupational Therapy evaluation and treatment. Resident Progress Notes contain no mention of any issues relevant to a need for Occupational Therapy. Disallowance will be included in the Final Report. See MDS Manual Section O.